# STATE OF MICHIGAN

# COURT OF APPEALS

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| HEATHER SWANSON,<br><br>Plaintiff-Appellee, | UNPUBLISHED<br>October 17, 2013 |
| v | No. 306409<br>St. Clair Circuit Court |
| JEANNIE L. ROWE, D.O., and BLUEWATER OBSTETRICS AND GYNECOLOGY, P.C.,<br><br>Defendants-Appellants. | LC No. 04-002438-NH |

Before: SAAD, P.J., and SAWYER and JANSEN, JJ.

PER CURIAM.

In this medical-malpractice action, defendants appeal by leave granted the trial court's denial of their motion for summary disposition, directed verdict, or judgment notwithstanding the verdict (JNOV). We affirm.

This action has a long and protracted procedural history including previously consolidated appeals. Plaintiff's theory is that defendants committed medical malpractice "during a laparoscopic procedure to remove an ovarian cyst result[ing] in a puncture wound to [plaintiff's] aorta and then a scar around her naval as a result of a laparotomy performed to repair the aorta." *Swanson v Port Huron Hosp (On Remand)*, 290 Mich App 167, 170; 800 NW2d 101 (2010). Following remand by this Court, *id*. at 186, the trial court scheduled the matter for retrial. Defendants filed a motion for dismissal, alternatively seeking summary disposition, a directed verdict, or JNOV. In support of their motion, defendants asserted that plaintiff had failed to present sufficient evidence at trial regarding her theory that defendants' were negligent in the performance of her surgery. Defendants argued that plaintiff's only evidence of negligence was the testimony and opinion of her expert, Jon Michael Hazen, M.D., that defendants inserted the Veress needle or trocar at an improper angle resulting in damage to the aorta. Defendants contended that this was contrary to the evidence established by the testimony of Rowe, as well as Laura Williams, who assisted in the procedure. In addition, defendants pointed to evidence that the laparoscopic procedure was a "blind procedure," and that a known risk of possible injury to "blood vessels" was associated with the procedure even in the absence of negligence. Given this Court's determination that the doctrine of res ipsa loquitur was not applicable, see *id*. at 185, defendants contended that there was no evidence from which a jury could find a breach of the standard of care as asserted by plaintiff and her expert, Hazen. Plaintiff responded by asserting that Hazen's opinion was supported by reasonable inferences

arising from the evidence. The trial court denied defendants' motion without prejudice. We granted defendants' application for leave and stayed further proceedings pending the outcome of this appeal. *Swanson v Rowe*, unpublished order of the Court of Appeals, entered October 20, 2011 (Docket No. 306409).

"This Court reviews de novo a trial court's decision with regard to both a motion for a directed verdict and a motion for JNOV." *Taylor v Kent Radiology, PC*, 286 Mich App 490, 499; 780 NW2d 900 (2009); see also *Sniecinski v Blue Cross & Blue Shield of Mich*, 469 Mich 124, 131; 666 NW2d 186 (2003). "A trial court properly grants a directed verdict only when no factual question exists upon which reasonable minds could differ. Similarly a motion for JNOV should be granted only when there is insufficient evidence presented to create an issue of fact for the jury." *Heaton v Benton Constr Co*, 286 Mich App 528, 532; 780 NW2d 618 (2009) (citation omitted). Similarly, the grant or denial of a motion for summary disposition is reviewed de novo. *Reed v Breton*, 475 Mich 531, 537; 718 NW2d 770 (2006).

A trial court's decision to admit the testimony of an expert is reviewed for an abuse of discretion. *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006); *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004). The interpretation of evidentiary rules is reviewed de novo. *Chapin v A & L Parts, Inc*, 274 Mich App 122, 126; 732 NW2d 578 (2007).

Defendants contend that, following this Court's determination that the trial court erred by providing a res ipsa loquitur instruction to the jury, the trial court erred once again by failing to dismiss plaintiff's claims. Defendants contend that the opinion of plaintiff's expert was not premised on, and did not comport with, the factual evidence in this case. Specifically, defendants argue that Hazen's assertion that Rowe improperly inserted the Veress needle or trocar perpendicularly rather than at an appropriate angle or with too much force was contrary to the testimony of eyewitnesses. Defendants further argue that the risk of injury to blood vessels during this type or procedure is a known, albeit rare, risk, even absent any negligence.

"'In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants.'" *Teal v Prasad*, 283 Mich App 384, 390-391; 772 NW2d 57 (2009), quoting MCL 600.2912a(2). "To establish medical malpractice, a plaintiff must prove the following elements: (1) the applicable standard of care, (2) breach of that standard, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Velez v Tuma*, 283 Mich App 396, 398; 770 NW2d 89 (2009), rev'd in part on other grounds 492 Mich 1 (2012). As with any claim of negligence, the burden is on the plaintiff to produce evidence sufficient to establish a prima facie case on each element. See *Berryman v Kmart Corp*, 193 Mich App 88, 91-92; 483 NW2d 642 (1992).

As observed by this Court in *Robins v Garg*, 276 Mich App 351, 362; 741 NW2d 49 (2007):

> "Proximate cause" is a term of art that encompasses both cause in fact and legal cause. "Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or 'but for') that act or omission." Cause in fact may be established by circumstantial evidence, but the

> circumstantial evidence must not be speculative and must support a reasonable inference of causation. "'All that is necessary is that the proof amount to a reasonable likelihood of probability rather than a possibility.'" [Citations omitted.]

It is recognized that the evidence adduced "'need not negate all other possible causes, but such evidence must exclude other reasonable hypotheses with a fair amount of certainty.'" *Skinner v Square D Co*, 445 Mich 153, 166; 516 NW2d 475 (1994) (citation omitted). "[T]he causation theory must demonstrate some basis in established fact." *Ykimoff v Foote Mem Hosp*, 285 Mich App 80, 87-88; 776 NW2d 114 (2009).

A plaintiff is required to plead his or her theory of medical malpractice with specificity, and the proofs submitted must be in accord with the theories pleaded. *Badalamenti v William Beaumont Hosp-Troy*, 237 Mich App 278, 284; 602 NW2d 854 (1999). In a medical-malpractice case, the burden is on the proponent of the expert testimony to establish that the expert is qualified and that the opinion rendered is reliable. *Clerc v Chippewa Co War Mem Hosp*, 477 Mich 1067, 1068; 729 NW2d 221 (2007). In addition:

> [A]n expert's opinion is objectionable where it is based on assumptions that are not in accord with the established facts. This is true where an expert witness' testimony is inconsistent with the testimony of a witness who personally observed an event in question, and the expert is unable to reconcile his inconsistent testimony other than by disparaging the witness' power of observation. [*Badalamenti*, 237 Mich App at 286 (citations omitted).]

At trial, defendants provided evidence, through the testimony of Rowe and Williams, as eyewitnesses in the operating room, as well as the testimony of two experts, Samuel Gene McNeeley, M.D. and William Floyd, M.D., to support their theory that the actions undertaken by Rowe comported with the applicable standard of care.

Rowe indicated that insertion of the Veress needle and trocar constituted a "blind procedure." In other words, at the point of insertion, the physician is unable to view the patient's internal anatomical structures. Rowe acknowledged the need to insert the trocar and Veress needle on an angle, indicating, "I insert in a slight caudal angle, which is towards the feet, downward but it was [at] slight angle, as I'm lifting up on the abdomen." Similarly, in her deposition, Rowe opined that the Veress needle was inserted at a "slight caudal angle." When Rowe was questioned at her deposition regarding the specific degree of the angle of insertion, the following colloquy occurred:

> *Q.* What is that angle in degrees?
>
> *A.* I couldn't give you an exact degree. It's just a slight angle downward towards her feet versus straight on, versus straight perpendicular.
>
> * * *
>
> *A.* I did not measure the exact angle putting it in her, but I know it was a slight angle towards the feet.

* * *

*Q.* So this slight angle that you described is somewhere between zero and 90 degrees?

*A.* Yes.

*Q.* Is it closer to 90 degrees or zero?

*A.* It's a slight angle closer to 90 degrees.

* * *

*A.* [I]t can vary from person to person. You're holding up on the belly as you're going in, so the tissue angle is hard to say exactly because you're going at a slight angle, but the tissue may not be exactly flat as you're going in. . . . As I'm pulling up, her abdomen is tented up, and so as I'm going in at an angle, it still may not be—I can't give you the exact degree based on her because it depends on how much tenting up you're doing.

Rowe indicated that she did not observe any bleeding or blood when she withdrew the Veress needle. Blood was initially observed after placement of the camera, "directly underneath where the camera went in." Rowe did not observe any additional or continued bleeding while she proceeded to drain the cyst on plaintiff's ovary.

After draining the cyst, Rowe was "backing the camera out" when she looked "upward" to view the "liver and the gallbladder just to make sure that everything looks normal there. . . . And as I was swinging the camera around towards her right side and looking upward, I saw this area in the retroperitoneal area that looked like a mass." Uncertain "what kind of mass would be right underneath the retroperitoneum," Rowe consulted with a surgeon. When Rowe observed "pulsating" of the mass, she immediately contacted a vascular surgeon for assistance.

Dr. Khattab Joseph, a vascular surgeon, came to the operating room and repaired plaintiff's aorta. When Joseph entered the operating room he spoke with Rowe, "looked at the scope, the camera, and I found pulsatile expanding hematoma on top of the aorta." When questioned regarding the distance between the "exterior surface of [plaintiff's] umbilicus" and the aorta, Joseph indicated he did not conduct measurements and that the location of these structures is variable based on the weight of the person and individual idiosyncrasies. Specifically, Joseph opined that the location of the aorta is not as deep in "skinnier people" when compared to "obese people." Joseph opined that the laceration of plaintiff's aorta was "very small," constituting only approximately "two millimeters" and was "rounded just like a nail" or "like a needle puncture." Joseph believed the Veress needle, and not the trocar, was the source of the puncture "because it was very small" and "did not even open the aorta." Joseph consistently described the laceration as "very, very small. The smallest [that] can let it get some blood out. I didn't measure it. But the smallest to leak blood out." In identifying the laceration "at the distal portion of the aorta," Joseph indicated:

> That's approximately around the naval, the belly button. It could be exactly underneath. It could be a little lower. It could be a little higher. Not all the people are in the same . . . thing.

When questioned regarding the location of the abdominal aorta in relationship to the umbilicus, Rowe responded that the aorta is "in the field of the surgery," and that its position "could be directly underneath, it could be slightly lower, it could be slightly above. Every person is slightly different." At her deposition, Rowe responded to similar questioning as follows:

> *Q.* Is [plaintiff's] aorta in an odd position as compared to the rest of the population that you've operated on?
>
> *A.* Not that I'm aware of, no.
>
> *Q.* Her aorta is where it's supposed to be according to textbooks and all that, right?
>
> *A.* Each person is slightly different, but in general, yes.

Laura Williams was the surgical technologist assisting Rowe with the procedure. She concurred with Rowe that the Veress needle and trocar used during the procedure were placed at an angle and not straight down into the patient. Williams also indicated that she did not observe blood in the cul-de-sac of the peritoneum.

Defendants' expert, Samuel Gene McNeeley, M.D., concurred that the initial stages of a laparoscopy, involving the insertion of the needle and trocar, are "blind procedures," and that a "known complication of laparoscopy in general" includes "injury to the major blood vessels" such as "the aorta, the vena cava, the external iliac artery veins and then the internal iliac artery vein." McNeeley noted that "anatomical variances" exist "between people as to the relationship between the bifurcation of the aorta and the umbilicus[.]" Specifically, McNeeley opined:

> And about two percent of the patients that I've treated with this type of surgery we've had the bifurcation at the pelvic brim or into the pelvis, so up to two or three inches below where it would normally be found. Not common, but it certainly does occur.

McNeeley agreed that an injury such as plaintiff's could occur despite a physician's proper performance of the procedure. Based on his review of the records and his experience, McNeeley believed the injury was the result of the needle rather than the trocar because of the "size of the described hole by Doctor Joseph in the operative report" when compared to injuries from a trocar, which are typically "more pronounced with . . . arteries . . . more likely to see blood spurting throughout the entire field." When asked how injury had incurred, McNeely stated:

> I'm saying I was asked to possibly explain why the aorta was injured, and my only explanation that I thought that the jury might understand is that in my practice in unusual surgery the vessels are not in, in a perfect place one percent of

> the time. And I think the vascular surgeon suggested that, as well. Sitting here today, I don't know where [plaintiff's] aorta is.

McNeeley further testified:

> Major vessel injury, whether it is the artery, aorta, extra iliac or common iliac or internal iliac is a known complication of laparoscopy and in and of itself is not malpractice.

McNeeley believed, with a "reasonable degree of medical certainty," that the injury occurred because plaintiff's aorta rested lower than the umbilicus.

Defendants' other expert, William Floyd, M.D., concurred that the procedure performed on plaintiff was a "blind procedure" and that the potential for vascular injury was a known risk, even in the absence of negligence. Floyd opined that considerable "anatomical variation" exists "in all humans. And there are arteries that even in bifurcation of aorta you may have enough anatomical change that it, you wouldn't recognize it from a diagram." He opined that the fluid photographed during the procedure was from the cyst and not blood from the puncture of the aorta. Floyd asserted that "[m]ost injuries to the vena cava and the aorta are done by the Veress needle." As such, while injuries to the aorta during these procedures are "rare," Floyd asserted that they are not "100 percent preventable" and are a "known complication."

Plaintiff's expert, Jon Michael Hazen, M.D., focused on "the direction of the needle" as being "very important." Hazen opined that there was little or no risk of injury to any major blood vessels if the procedure was performed within the standard of care. Specifically, Hazen opined:

> If you're using proper technique, the direction that you put in the needle into the trocar should be away from these structures. In other words the only way this aorta or the big blood vessels just below the umbilicus can be injured is if someone inserts the instrument straight down. The recommended procedure is to put the, is to aim the instrument at 45 degrees or towards the hollow of the sacrum. In other words, away from this area. You can't hit those blood vessels if you do that.

Hazen testified that "the only way that this injury could have occurred is if improper technique had been used and that the major blood vessel to the aorta was actually stabbed with one of these instruments." Hazen further stated:

> My opinion is it most likely was the trocar. That's the large instrument we are talking about. The needle is a possibility, but it's hard to do it with the needle because the needle goes in the tissue, into the abdominal wall easier. And the only purpose of the needle is to put it in to run the gas in.
>
> So you don't have to insert it in any depth, and in Doctor Rowe's description of her operation she described testing after she put needle in where a syringe of saline, looks like water, where she put some in and aspirated. She saw no blood at that point.

> When she put the large trocar in and then put the scope in afterwards, she described seeing bright red blood. Bright red blood is arterial. Your venus blood is dark maroon, almost blue. Arterial blood is bright red, just candy apple red.

In part, Hazen's opinion that the trocar caused the injury was based on the use of the word "laceration" in the operative report by Rowe and Joseph, "indicating to me a linear or a line-like cut in the aorta. That's what a laceration is. A puncture is more of a round punched out area, which is what you commonly see with a blunt or that second trocar that we showed you . . . ." Had the needle been the source of injury, Hazen asserted, Rowe "would have gotten blood in the syringe."

Hazen further testified that the aortic laceration was located "straight down" from plaintiff's umbilicus. Specifically, "the position of the bifurcation is in [the] area of the umbilicus, and whether it's a quarter inch lower or a quarter inch higher, it's still straight down. It's nowhere near where the trocar should have been inserted." Hazen concurred with statements by Rowe and other witnesses for defendants regarding variations in individual anatomy, noting "[t]he bifurcation and the puncture is slightly up or down different in each patient. . . . That's normal."

But Hazen disagreed that "the risk of injury to the aorta during a laparoscopy procedure is .2 percent or two out of a thousand." During his deposition, Hazen had conceded that "[t]he most life-threatening laparoscopic complications are those to large retroperitoneal blood vessels, injuries to the aorta, inferior vena cava, or iliac vessels." He opined that the risk of injury to the aorta in such procedures is "1 in 10,000." Ultimately, Hazen testified:

> I think the important issue is some instrument that was used by Doctor Rowe was placed straight down into a portion of the aorta. Whether it was the needle or the trocar, I think is up for debate. Neither one of them should have been anywhere near the aorta or she would not have had a hole in the aorta, would not have bled, would not have needed the surgery that saved her life by Doctor Joseph.

In challenging the admissibility of Hazen's testimony, defendants mistakenly equate this Court's previous ruling regarding the impropriety of the res ipsa loquitur instruction with their present argument that there is no genuine factual dispute concerning the occurrence of negligence in this case. According to defendants, Hazen's assertions that Rowe improperly inserted the instruments during the procedure conflicts with the facts as established through the testimony of those present in the operating room and, therefore, is inadmissible. Without Hazen's unsupported testimony, defendants argue, plaintiff is unable to meet her burden of proving the requisite elements for her claim of medical malpractice. We disagree with defendants because, for the reasons that follow, we conclude that Hazen had proper evidentiary support for his testimony.

MRE 702 provides:

> If the court determines that recognized scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to

> determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

In general, "[e]xpert testimony is required to establish the standard of care and a breach of that standard, as well as causation[.]" *Kalaj v Khan*, 295 Mich App 420, 429; 820 NW2d 223 (2012) (citations omitted). "While there 'must be facts in evidence to support the opinion testimony of an expert,' circumstantial proof that enables reasonable inferences is sufficient." *Id.* (citations omitted).

Our Supreme Court has discussed the trial court's gatekeeping role in the application of MRE 702 to ensure that expert testimony is premised on sufficient data and is reliable. *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 779; 685 NW2d 391 (2004). "Careful vetting of all aspects of expert testimony is especially important when an expert provides testimony about causation." *Id*. at 782. The trial court "may admit evidence only once it ensures, pursuant to MRE 702, that expert testimony meets that rule's standard of reliability," by undertaking "a searching inquiry" of the data that serves as the foundation for the expert testimony, in addition to "the manner in which the expert interprets and extrapolates from those data." *Id*. "The inquiry is into whether the opinion is rationally derived from a sound foundation." *Chapin*, 274 Mich App at 139.

An expert "must have an evidentiary basis for his own conclusions." *Green v Jerome-Duncan Ford, Inc*, 195 Mich App 493, 498; 491 NW2d 243 (1992). "[A]n expert's opinion is objectionable where it is based on assumptions that are not in accord with the established facts. This is true where an expert witness' testimony is inconsistent with the testimony of a witness who personally observed an event in question, and the expert is unable to reconcile his inconsistent testimony other than by disparaging the witness' power of observation." *Badalamenti*, 237 Mich App at 286 (citations omitted).

Defendants assert that the testimony of eyewitnesses Rowe and Williams—namely, that Rowe inserted the Veress needle and trocar at an angle during the surgery—precludes Hazen's opinion that plaintiff's injury was the result of a "perpendicular" or "straight down" insertion of the instruments. In other words, defendants contend that Hazen assumed facts contrary to the established record, rendering his opinion purely speculative.

It is true that both Rowe and Williams testified at trial that the needle and trocar were inserted at a "caudal" angle. However, neither Rowe nor Williams specified the magnitude of this angle. Moreover, during her deposition, Rowe acknowledged that the angle of insertion was "slight" and approximated "closer to 90 degrees." As such, there was a genuine factual dispute concerning whether the instruments were inserted at a proper or sufficient angle.

In addition, the witnesses' testimony that individual variations exist regarding the position of the bifurcation of the abdominal aorta in respect to the umbilicus does not automatically lead to the conclusion that there was no negligence during plaintiff's surgery. As noted, defendants' experts and Hazen concurred that such anatomical variability exists. Yet, in

the circumstances of this case, the evidence provides no indication that plaintiff's aortic bifurcation is located in an unexpected or anomalous position. Hence, while the evidence established that an injury of the type experienced by plaintiff *could* occur in the absence of negligence (thereby making the res ipsa loquitur instruction inappropriate), it does not necessarily follow that defendants were not negligent in this particular case.

Hazen premised his testimony and opinion on his experience, his knowledge of anatomy, and the admissible evidence—*not* on mere assumptions. Accordingly, this case is distinguishable from those cases in which an expert assumes certain facts to be true even though they are wholly unsupported by the evidence. Cf. *Green*, 195 Mich App at 498-500; *Badalamenti*, 237 Mich App at 286-289. Hazen's disagreement with the interpretation of the evidence does not render his opinion mere speculation. *Robins*, 276 Mich App at 363. Although Hazen disagreed with defendants' experts, his opinion did not contradict the establish facts. *Id*. While the trier of fact might ultimately question Hazen's interpretation of the evidence, such an inquiry goes to the weight and credibility of the testimony, and is not a proper ground for summary disposition or dismissal. See *Skinner*, 445 Mich at 161.

Defendants also assert that plaintiff waived her argument that Rowe was negligent by using too much force when inserting the instruments because she did not specifically raise it at oral argument in response to defendants' motion for dismissal. Defendants' assertion is without merit. Indeed, defendants acknowledged in their motion that plaintiff's theory of liability included the allegation that Rowe had "used too much force inserting [the instruments]." The mere fact that oral argument was limited to the issue of the angle of insertion does not preclude plaintiff from pursuing her corollary argument that excessive force was a cause of the injury, which was an issue at the initial trial.

Affirmed. As the prevailing party, plaintiff may tax costs pursuant to MCR 7.219.

/s/ Henry William Saad
/s/ David H. Sawyer
/s/ Kathleen Jansen